**Form 6 YCMC Patient's Individual Authorization**

CHANGING YOUR MIND ABOUT THIS AUTHORIZATION I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY GIVING NOTICE TO THE PRIVACY OFFICER AT YOUR OFFICE. HOWEVER, I UNDERSTAND THAT I MAY NOT REVOKE THIS AUTHORIZATION FOR ANY ACTION TAKEN BEFORE RECEIPT OF MY WRITTEN NOTICE TO REVOKE THIS AUTHORIZATION. IN ADDITION, I UNDERSTAND THAT IF I AM GIVING THIS AUTHORIZATION AS A CONDITION OF OBTAINING INSURANCE COVERAGE, AND I REVOKE THIS AUTHORIZATION, THE INSURANCE

COMPANY HAS A RIGHT TO CONTEST MY CLAIMS UNDER THE INSURANCE POLICY. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT I UNDERSTAND THAT UNDER MOST CIRCUMSTANCES A HEALTHCARE PROVIDER MAY NOT CONDITION TREATMENT, PAYMENT, ENROLLMENT, OR ELIGIBILITY FOR BENEFITS ON MY SIGNING THIS AUTHORIZATION. HOWEVER, I UNDERSTAND THAT SIGNING AN AUTHORIZATION THAT PERMITS THE USE AND/OR

DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR RESEARCH PURPOSES MAY HAVE CONDITIONS OF MY TREATMENT, IF I AM UNDERGOING RESEARCH-RELATED TREATMENT. ALSO, I MAY BE REQUIRED TO SIGN AN AUTHORIZATION IF MY TREATMENT IS PROVIDED SOLELY FOR THE PURPOSE OF CREATING PROTECTED HEALTH INFORMATION FOR DISCLOSURE TO A THIRD PARTY. AND UNDER SOME CIRCUMSTANCES, A HEALTH PLAN MAY CONDITION MY ENROLLMENT IN A HEALTH PLAN OR MY ELIGIBILITY FOR BENEFITS ON MY PROVIDING AND AUTHORIZATION PERMITTING THE HEALTH PLAN TO MAKE ENROLLMENT AND ELIGIBILITY DETERMINATIONS.

INDIVIDUAL PATIENT’S SIGNATURE I HAVE HAD THE CHANCE TO READ AND THINK ABOUT THE CONTENT OF THIS AUTHORIZATION FORM AND I AGREE WITH ALL STATEMENTS MADE IN THIS AUTHORIZATION. I UNDERSTAND THAT, BY SIGNING THIS FORM, I AM CONFIRMING MY

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION DESCRIBED IN THIS FORM WITH THE PEOPLE AND/OR ORGANIZATIONS NAMED IN THIS FORM.

**Patient's Signature**

**Date**

**Describe each purpose for which you are authorizing your protected health information to be used and/or disclosed:**

**ENDING THIS AUTHORIZATION Select one of the following two choices:**

 This authorization will end on the following

 The authorization will end when 

the following event happens. The

dates event must relate to the individual or

the purpose of the authorized use and/or disclosure. Describe the event below:

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT

**New Field8**